

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | | | | | | | | | 07611 | |
|---|--|--|--|---|--|---|--|--|-----------------------|--|--|
| 1. FOR STATE REGISTRAR | | REG. NO. | | | | | | | | | |
| 1. DECEASED NAME (TYPE OR PRINT) William Vernon Blades, Sr. | | | | | | 2a. DATE OF DEATH MONTH DAY YEAR 03-20-84 | | | 2b. HOUR 2:10 P.M. | | |
| 3. SEX Male | | 4. RACE White | | 5. DATE OF BIRTH MONTH DAY YEAR 10 23 1896 | | 6. AGE (IN YEARS LAST BIRTHDAY) 87 YRS. | | IF UNDER 1 YEAR MONTHS DAYS | | IF UNDER 24 HRS HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland | | 7b. CITIZEN OF WHAT COUNTRY? USA | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Caroline MD. | | | | | |
| 10. CITY OR TOWN OF DEATH Denton | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Wesleyan Health Care Center | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Farmer | | 12b. KIND OF BUSINESS OR INDUSTRY Farm | | | |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | | | | | | | | | | |
| 13a. STATE Maryland | | 13b. COUNTY Caroline | | 13c. CITY OR TOWN Ridgely | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS P.O. Box 114 | | 21660 | |
| 14. FATHER'S NAME FIRST MIDDLE LAST Alonza Blades | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Lona Broadus | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No | | | | 16b. SOCIAL SECURITY NO. 220-12-1437 | | 17. INFORMANT ADDRESS Della Marie Blades Ridgely, Maryland | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardio pulmonary Arrest</u> 1629 DUE TO, OR AS A CONSEQUENCE OF (b) <u>Metastatic Lung Carcinoma</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <u>Chronic Renal Failure & Electrolyte Disturbance</u> | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 19 <u>3/20</u> , to 19 <u>24</u> , that (I) (we) last saw the deceased alive on <u>3/20</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE Samuel A. Bricker | | | | DEGREE MD ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | | | 22c. DATE SIGNED 3/20/84 | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) SAMUEL A. BRICKER | | | | 22e. ADDRESS | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b. DATE 3-23-84 | | 23c. NAME OF CEMETERY OR CREMATORY Hillcrest Cemetery | | 23d. LOCATION CITY OR TOWN COUNTY STATE Federalsburg CA MD | | | | | |
| 24. FUNERAL DIRECTOR NAME Boulais Funeral Home | | | | | | ADDRESS Greensboro, MD | | 25a. DATE REC'D. BY REGISTRAR MAR 27 1984 | | | |
| | | | | | | 25b. REGISTRAR'S SIGNATURE Julia Davidson-Rodriguez | | | | | |

UNITED STATES DEPARTMENT OF AGRICULTURE
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U.S. DEPT. OF AGRICULTURE



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TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked as item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE 07612
CERTIFICATE OF DEATH

| | | | |
|--|-------------------------|---|--|
| 1. FOR - STATE REGISTRAR | | REG. NO. | |
| 1. DECEASED NAME (TYPE OR PRINT) John D. Butler | | 2a. DATE OF DEATH MONTH DAY YEAR March 26, 1984 | |
| 3. SEX Male | 4. RACE Negro | 5. DATE OF BIRTH MONTH DAY YEAR July 17, 1926 | |
| 6. AGE (IN YEARS LAST BIRTHDAY) 57 YRS. | | 7b. HOUR M | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Forest, Mississippi | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Caroline MD. | |
| 10. CITY OR TOWN OF DEATH Preston | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Rt. 2, Box 23 | |
| 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Laborer | | 12b. KIND OF BUSINESS OR INDUSTRY Saw Mill | |
| 13a. STATE Maryland | | 13b. COUNTY Caroline | |
| 13c. CITY OR TOWN Preston | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 14. FATHER'S NAME FIRST MIDDLE LAST Henry Butler | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Rose Pase | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) Unknown | | 16b. SOCIAL SECURITY NO. 425-40-6071 | |
| 17. INFORMANT ADDRESS Michigan 48503 | | 17. INFORMANT Bertha Denson, 717 Pingree Ave., Flint, | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cause of the lung w/ cerebral metastasis 1629 Conditions, if any, which gave rise to immediate cause (b), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ DUE TO, OR AS A CONSEQUENCE OF | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 6 mo. | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> HOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | |
| 21c. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21d. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | |
| 21e. LOCATION STREET CITY OR TOWN COUNTY STATE | | | |
| 22. I certify that (I) (this hospital) attended the deceased from _____ 19_____, to _____ 19_____, that (I) (we) last saw the deceased alive on _____ 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If we) (I) did not view the body after death. | | | |
| 22a. SIGNATURE Lawrence Bohan, M.D. | | 22b. ADDRESS Ditchmans Lane, Easton, Maryland 21601 | |
| 22c. PHYSICIAN'S NAME (TYPE OR PRINT) Lawrence Bohan, M.D. | | 22d. DATE SIGNED 3-26-84 | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b. DATE Apr. 1, 1984 | |
| 23c. NAME OF CEMETERY OR CREMATORY Hillsborough Cemetery | | 23d. LOCATION CITY OR TOWN COUNTY STATE Hillsborough, Scott Co., Miss. | |
| 24. FUNERAL DIRECTOR NAME ADDRESS Frampton-Hawkins Funeral Home, 216 N. Main St., Federalburg, Md. | | 25. DATE REC'D. BY REGISTRAR APR 02 1984 | |
| | | 26. REGISTRAR'S SIGNATURE John Davidson-Pondella | |

BP



March 26, 1984

John D. Butler

27

July 17, 1983
deceased

known

male

Caroline

Forest, Maryland U.S.A.

See file

laborer

Box 2, Rt. 2

Frederick

Box 2, Rt. 2

Frederick Caroline

Maryland

Home base

Henry Butler

Richard 08507

437-40-0071 Death record, 1711 Rittenberg Ave., N.W., Wash, D.C.

Unknown

Witchman's Lane, Boston, Maryland 21001

Lawrence Cohen, M.D.

Serial

Nov. 1, 1984

Hillspoor Cemetery Hillspoor, Scott Co., Ia.

Federal Bureau of Investigation

Washington-Hawkins Funeral Home, 210 N. Main St.,

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IMPORTANT: If item 21 is marked as (1), it shows a violent injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | | | | | | | | | | | | |
|---|--|---|--|--|--|---|--|--|--|-----------------|--|-----------------------------|--|
| 1. FOR STATE REGISTRAR | | 7. REG. NO. | | 0 7 6 1 3 | | | | | | | | | |
| 1. DECEASED NAME (TYPE OR PRINT) | | | | 2a. DATE OF DEATH | | MONTH | | DAY | | YEAR | | 2b. HOUR | |
| Harvey D. Dukes, Jr. | | | | 3 | | 25 | | 84 | | 9 | | 42 A.M. | |
| 3. SEX | | 4. RACE | | 5. DATE OF BIRTH | | 6. AGE (IN YEARS LAST BIRTHDAY) | | IF UNDER 1 YEAR | | IF UNDER 74 HRS | | | |
| Male | | White | | 5 16 98 | | XXX 85 YRS | | MONTHS | | DAYS | | HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH | | | | | | | |
| Maryland | | USA | | | | Caroline MD | | | | | | | |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | | | | | |
| Denton | | Wesleyan Health Care Center | | | | Minister | | Wesleyan Ch. | | | | | |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | | | | | | | | | | | | |
| 13a. STATE | | 13b. COUNTY | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET ADDRESS / ZIP CODE | | | | | |
| Maryland | | Caroline | | Greensboro | | | | Rt. 1 Box 394A | | | | 21639 | |
| 14. FATHER'S NAME FIRST MIDDLE LAST | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST | | | | | | | | | |
| Harvey D. Dukes, Sr. | | | | Laura Sturgis | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) | | | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS | | | | | | | |
| No | | | | 219-34-3584 | | Mabel M. Dukes Greensboro, MD | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | | | | | | | | | | | | |
| PART I. DEATH WAS CAUSED BY: | | | | | | | | | | | | | |
| IMMEDIATE CAUSE (a) Cardio respiratory Arrest | | | | | | | | | | | | | |
| 3109 DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | | | | |
| (b) Pneumonia | | | | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | | | | |
| (c) Severe Organic Brain Syndrome | | | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: | | | | | | | | | | | | | |
| Schizophrenia | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | | | | | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | | | | | |
| 22a. I certify that (1) this hospital attended the deceased from 1/3 19 84 to 3/25 19 84, that (1)(we) last saw the deceased alive on 3/24 19 84, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1)(we) (did) (did not) view the body after death. | | | | | | | | | | | | | |
| 22b. SIGNATURE Samuel Q. Bricker | | | | DEGREE MD | | | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | | | 22c. DATE SIGNED 3/25/84 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) Samuel Q. Bricker, M.D. | | | | 22e. ADDRESS Denton, MD | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION CITY OR TOWN COUNTY STATE | | | | | | | |
| Burial | | 3-28-84 | | Lakeside Cemetery | | Dover Kent DE | | | | | | | |
| 24. FUNERAL DIRECTOR NAME ADDRESS | | | | | | | | | | | | | |
| John E. Boulard Greensboro, MD | | | | | | | | | | | | | |



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED. WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DHMH - 17
(VR A15 ME (5))
15M 2/80

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH | | | | | | | | | | REG. NO. 7614 | | | |
|--|--|-------------------------|--|--|--|---|--|--|--|---|--|---------------------------|--|
| 1- FOR STATE REGISTRAR | | | | | | | | | | 2a. DATE KNOWN OF DEATH | | 2b. HOUR | |
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Michael Lee Rader | | | | | | | | | | MONTH DAY YEAR X 3/6/84 | | M 9 | |
| 3. SEX Male | | 4. RACE white | | 5. DATE OF BIRTH MONTH DAY YEAR 2/28/1945 | | 6. AGE (IN YEARS) (LAST BIRTHDAY) MONTHS DAYS HOURS MIN. 39 YRS. | | IF UNDER 1 YR. IF UNDER 24 HRS. | | 7c. DATE PRONOUNCED DEAD MONTH DAY YEAR 3/6/84 | | 7d. HOUR M 2:30 | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Virginia | | | | 7b. CITIZEN OF WHAT COUNTRY? USA | | | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Caroline Co. | | | |
| 10. CITY OR TOWN OF DEATH Greensboro | | | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION RFD Fox Grape Farm Road | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Unemployed | | 12b. KIND OF BUSINESS OR INDUSTRY Laborer | | | |
| 13a. STATE Md. | | | | 13b. COUNTY Caroline | | 13c. CITY OR TOWN Greensboro | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET ADDRESS RFD | | 21639 | |
| 14. FATHER'S NAME FIRST MIDDLE LAST Jacob K. Rader | | | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Jacqueline Hunley | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) yes | | | | 16b. SOCIAL SECURITY NO. 1966 | | 17. INFORMANT ADDRESS Mrs. Joan Rader | | | | 21639 Greensboro, Md. | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Intracranial Trauma 9550 Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last: (b) 38 calibre Shell Self Inflicted (c) Depression APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH sec sec Montyd | | | | | | | | | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | | | 20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH as above | | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) Self inflicted told wife he would do it | | | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK | | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) near Home above | | 21f. LOCATION (STREET) CITY OR TOWN COUNTY STATE address | | | | | | | |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . | | | | | | | | | | | | | |
| ACTUAL SIGNATURE Harold B. Plummer | | | | TITLE (SPECIFY) Asst. Deputy | | | | DATE SIGNED 3/9/84 | | | | | |
| EXAMINER'S NAME (TYPE OR PRINT) Preston, Md. 21655 | | | | ADDRESS P.O. Box #129 | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL Burial | | | | 23b. DATE 3/9/84 | | 23c. NAME OF CEMETERY OR CREMATORY Chester Cemetery | | 23d. LOCATION (CITY OR TOWN) COUNTY STATE Chestertown, Md. | | | | | |
| 24. FUNERAL DIRECTOR NAME Julius Wells | | | | | | ADDRESS Chestertown, Md. | | 25a. DATE REC'D. BY REGISTRAR MAR 16 1984 | | | | | |
| | | | | | | | | 25b. REGISTRAR'S SIGNATURE Julia Davidson-Randall | | | | | |

BP



CONFIDENTIAL

CONFIDENTIAL

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TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon-papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

7 6 1 5

1 - FOR
STATE
REGISTRAR

REG. NO.

| | | | | | | | | | |
|---|--|---|---|---|---|--|--|--|--|
| 1. DECEASED NAME (TYPE OR PRINT) Joanna Elizabeth Spiering | | | 2a. DATE OF DEATH MONTH DAY YEAR 3 28 84 | | | 2b. HOUR 11 P.M. | | | |
| 3. SEX Female | | 4. RACE Cau. | | 5. DATE OF BIRTH MONTH DAY YEAR 6-14-90 | | 6. AGE (IN YEARS LAST BIRTHDAY) YRS. 93 | | IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Pa. | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Caroline Co. MD. | | | |
| 10. CITY OR TOWN OF DEATH Denton | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Caroline Neg Home | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife | | 12b. KIND OF BUSINESS OR INDUSTRY none | | | |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Md. 13b. COUNTY Caroline 13c. CITY OR TOWN Greensboro | | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET ADDRESS Boyce Mill Road 21639 | | | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST Karl W. Schaller | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Wilhelmina Beck | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) no | | 16b. SOCIAL SECURITY NO. 212-40-7789 | | 17. INFORMANT Glen Spiering | | ADDRESS Greensboro, Md. | | | |
| 18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: 4275 IMMEDIATE CAUSE (a) Cardiopulmonary arrest DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE C. M. Lipsitz | | | | | | DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED 3/29/84 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) C. M. LIPSITZ | | | | | | 22e. ADDRESS | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | | 23b. DATE 3-31-84 | | 23c. NAME OF CEMETERY OR CREMATORY Greensboro Cemtery | | 23d. LOCATION CITY OR TOWN COUNTY STATE Greensboro Caroline Md. | | |
| 24. FUNERAL DIRECTOR John E. Bouleau | | | | | | 25a. DATE RECEIVED BY REGISTRAR APR 6 1984 | | | |
| ADDRESS Greensboro, Md. | | | | | | 25b. REGISTRAR'S SIGNATURE John Davidson-Randall | | | |

BP _____



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DHM-17
(VR A15 ME (5))
15M 2/80

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH | | | | | | | | | | | |
|---|--|-----------------------------|--|--|--|--|--|---|-------------------------|---|--|
| 1- FOR STATE REGISTRAR | | | | | | | | | | | |
| 1. DECEASED NAME (TYPE OR PRINT) William Raymond Wallace | | | | | | 2b. DATE KNOWN OF DEATH ESTIMATED <input checked="" type="checkbox"/> MONTH 3 DAY 7 YEAR 1984 | | | 2d. HOUR 3:30 AM | | |
| 3. SEX Male | | 4. RACE Cau. | | 5. DATE OF BIRTH MONTH 8 DAY 6 YEAR 24 | | 6. AGE (IN YEARS) (LAST BIRTHDAY) 59 YRS. | | IF UNDER 1 YR. MONTHS 0 DAYS 0 | | IF UNDER 24 HRS. HOURS 0 MIN 0 | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) N.J. | | | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH CAROLINE MD. | |
| 10. CITY OR TOWN OF DEATH Greensboro | | | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 406 N. Main St. | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Disabled American Veteran | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| 13a. STATE Md. | | 13b. COUNTY Caroline | | 13c. CITY OR TOWN Greensboro | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS 406 N. Main St. | | 21639 | |
| 14. FATHER'S NAME FIRST Arthur MIDDLE O. LAST Wallace | | | | 15. MOTHER'S MAIDEN NAME FIRST Irene MIDDLE V. LAST Ejrre | | | | 16. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) yes (IF YES, GIVE WAR OR DATES) WW 11 | | | |
| 16a. SOCIAL SECURITY NO. 189-18-4252 | | | | 17. INFORMANT ADDRESS Coles-Doley Funeral Home, Swedesboro N.J. | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: 4100 IMMEDIATE CAUSE (a) Myocardial INFARCTION Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last: (b) Arteriosclerotic Cardiovascular disease (c) Anemia, CARCINOMA, Ascites | | | | | | | | | | | |
| PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a): | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | 20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2) | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) | | | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . | | | | | | | | | | | |
| ACTUAL SIGNATURE Christian E. Jensen | | | | TITLE (SPECIFY) Deputy MEDICAL EXAMINER | | | | DATE SIGNED 3/7/84 | | | |
| EXAMINER'S NAME (TYPE OR PRINT) Christian E. JENSEN MD | | | | ADDRESS P.O. Box 690, Denton MD 21629 | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | | | 23b. DATE 3-12-84 | | | | 23c. NAME OF CEMETERY OR CREMATORY Lake Park Cemetery | | | |
| 23d. LOCATION CITY OR TOWN Swedesboro COUNTY Gloucester STATE N.J. | | | | 25a. DATE REC'D. BY REGISTRAR MAR 13 1984 | | | | 25b. REGISTRAR'S SIGNATURE Jula Davidson-Rondella | | | |
| 24. FUNERAL DIRECTOR NAME John E. Boula ADDRESS Greensboro, Md. | | | | | | | | | | | |

BP

CARDIAC

acute
chronic

Myocardial Infarction
Atherosclerotic (cardiovascular disease)

Anemia, CARCINOMA, Atherosclerosis

X X

3/10/84

Christian E. Jensen MD
Chief of Cardiology
St. Paul's Hospital
Portland, OR

1984 1 3 8:00 AM